19.9 weeks. A total of 56% of patients were diagnosed with SEA and 44% had a mixed eosinophilic-allergic phenotype. All patients received IGC+LABA at high doses. Thirteen patients were taking montelukast and two OGC at low doses; 53% (18) had received omalizumab previously.

Regarding effectiveness, mepolizumab decreased eosinophils from 840.6 (400–2012) to 143.75 (0–500) cells/ μ L, FeNO decreased to 17.14 (0–89) ppb, FEV₁ improved to 0.325 mL (0.12–0.65) and ACT improved to 6 points (2–9). With reslizumab, eosinophils decreased from 420 (100–1000) to 50 (0–100) cells/ μ L, FeNO decreased to 24.5 (0–35) ppb, FEV₁ improved to 0.4 mL (0.17–0.45) and ACT improved to 4 points (2–6). Benralizumab decreased eosinophils from 622.2 (0–1900) to 66.6 (0–600) cells/ μ L, FeNO decreased to 22.6 (0–43) ppb, FEV₁ improved to 0.36 mL (0.07–0.84) and ACT improved to 2.4 points (0–6). Two patients (10%) who received mepolizumab developed respiratory infection and one patient (5%) developed back pain. With benralizumab, two patients developed myalgias (22.2%) and one patient (11.1%) had diarrhoea.

Conclusion and relevance In conclusion, anti-IL-5 therapy was effective and safe. Adequate monitoring is needed to optimise treatment.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-143

TREATMENT OF ASTHMA AND CHRONIC OBSTRUCTION PULMONARY DISEASE: ARE OUR HOSPITAL NURSES AND PHYSICIANS READY TO TREAT AND EDUCATE INPATIENTS?

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10.1136/ejhp-pharm-2020-eahpconf.244

Background and importance In the treatment of asthma/chronic obstruction pulmonary disease (COPD), misuse of inhalation devices is common, with a higher risk of treatment inefficacy, side effects or acute exacerbations, leading to more hospitalisations. In hospital, nurses and doctors are expected to (re) assess patients' knowledge/ability to use their treatments for those hospitalised with severe asthma/COPD, particularly among the elderly population.

Aim and objectives Before implementing a procedure of patient assessment at admission, we conducted a hospital wide survey to appraise knowledge and current practices of nurses and doctors.

Material and methods We conducted an observational study by interviewing nurses and doctors from 12 care units (adults/geriatric, without respiratory specialisation) in August 2019. Two distinct questionnaires based on a literature review were developed by a multidisciplinary group, including three similar parts: knowledge about physiopathology and treatments (1); practices and self-confidence to educate patients (2); and professional training needs (3). Nurses were individually interviewed by a pharmacy resident while doctors answered an individual online questionnaire.

Results We interviewed 37 nurses, and 14/27 practitioners/interns responded to the questionnaire. The main results in part 1 were that 51.4% of nurses knew the characteristic symptoms of asthma, 45.9% considered budesonide a

bronchodilator and 14.3% of doctors knew that there were non-validated combinations of nebulisation drugs. In part 2, 48.6% of nurses and 14.3% of doctors declared that a patient's assessment is made at admission, partly due to the absence of a procedure and a lack of time, respectively; 60% of nurses told patients to rinse their mouth after inhalation of corticoids. In part 3, 78% of nurses were quite/totally confident about inhaler device use compared with 35.7% of doctors; doctors considered general practitioners and nurses the most appropriate professionals for patient education. We found that 84.1% of nurses and 92.9% of doctors were interested in specific training.

Conclusion and relevance The results showed a lack of knowledge of nurses/prescribers about some aspects of asthma/COPD, despite nurses' self-confidence. Among our patients, few were evaluated at admission on their ability to use their devices correctly, with the risk that their treatments may not be optimised. To improve knowledge of professionals and harmonise our practices, we aim to offer training and formalise a procedure for eligible patient evaluation/education at admission, thus ensuring better care.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-144

SAFETY AND EFFECTIVENESS OF REDUCED DOSE OMALIZUMAB FOR CHRONIC IDIOPATHIC URTICARIA

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10.1136/ejhp-pharm-2020-eahpconf.245

Background and importance Omalizumab, a monoclonal antibody that selectively binds to human immunoglobulin E, has been approved by the FDA for the treatment of chronic idiopathic urticaria (CIU) at two different dosing: 150 mg (reduced dose) and 300 mg monthly.

Aim and objectives To determine the safety and effectiveness of omalizumab in both doses for the treatment of CIU in our centre.

Material and methods This was an observational, descriptive, retrospective study of omalizumab prescribed for adult patients with CIU from January 2015 to September 2019 in a third level hospital. Variables collected were sex, age, service (allergy or dermatology), previous treatments, initial dose, dose change, clinical variable urticaria activity score 7 (UAS7), suspension of treatment and adverse reactions.

Results Fifty-two patients (67.31% women) with a median age of 50.5 years (range 23–75) were included: 65.38% (n=34) were from allergy and 34.62% from dermatology. All patients had previously received antihistamines, montelukast and ciclosporin. Only three patients started with a monthly dose of omalizumab of 150 mg while the rest (94.23% (n=49)) started with 300 mg monthly. However, in the last group of patients, 44.90% (n=22) required a dose change: in 68.18% (n=15) of patients, the dose was decreased to 150 mg monthly because of a good response and in the rest (31.82% (n=7)) the dose was intensified due to lack of disease control.

UAS7 was collected before and during treatment with omalizumab in only 69.23% of patients (n=36). Median UAS7 before treatment with omalizumab was 29.5 (range 2–42). During treatment, UAS7 was 0 (range 0–32) with both doses of omalizumab.

In total, 13.46% (n=7) of patients stopped treatment with omalizumab: 3 patients receiving a dose of 150 mg for improvement in disease, 3 for inefficiency and in 1 the reason was unknown. Adverse reactions occurred in 2 patients: 1 patient had alopecia and asthenia and another patient gained weight.

Conclusion and relevance There was a high percentage of patients in our centre who received a dose of omalizumab 300 mg monthly for CIU but a reduced dose (150 mg monthly) was equally effective and safe, even stopping treatment for improvement in CIU which would also have an economic impact.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-145 EVALUATION OF A PHARMACEUTICAL CARE PROGRAMME FOR PATIENTS BEING TREATED WITH OMALIZUMAB

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10.1136/ejhp-pharm-2020-eahpconf.246

Background and importance The problem of severe asthma refractory to treatment has been addressed in clinical practice guidelines but there is still a notable percentage of patients poorly controlled, under treated and with inadequate follow-up. The pharmacy service (PS) of a third level hospital proposed a pharmaceutical care programme (PCP) to dispense omalizumab in prefilled syringes for self-administration in hospital and subsequently the patient would self-administer at home.

Aim and objectives To evaluate the effectiveness and safety of treatment with omalizumab after implementation of a PCP for asthmatic patients treated with omalizumab in January 2019.

Material and methods In this observational retrospective study, all patients treated with omalizumab in our hospital and who had started the PCP were included. The primary endpoint was the degree of effectiveness and safety of omalizumab in patients with the new protocol. The effectiveness indicators used to compare the study periods were: the number of exacerbations due to asthma, asthma control test for people over 12 years of age (ACT12 score) and clinical status assessment of asthma by a doctor (reduction in forced expiratory volume in 1 s (FEV₁)). Exacerbation was defined as an increase in symptomatology that required systemic corticosteroid recovery treatment. Secondary endpoints included adherence to treatment and treatment modifications.

Results A total of 28 patients were evaluated, 50% women, with a mean age of 24 years (8–56), and an average treatment duration with omalizumab of 29 months (1–66). Since the introduction of the PCP, 18% of patients suffered exacerbations (1–4) with an average ACT12 score of 11: 40% of patients showed an improvement in FEV₁ and no patient reported a reaction at the injection site. Adherence to omalizumab was 96% but adherence to the basic treatment was only good in 45% of patients and was 0% in four patients.

Conclusion and relevance Implementation of the PCP allowed follow-up of efficacy and safety of omalizumab treatment.

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1. European public assessment report of omalizumab (https://www.ema.europa.eu/en/documents/product-information/xolair-epar-product-information_en.pdf).

I would like to express my great appreciation to the staff of the service.

No conflict of interest.

4CPS-146 EFFECTIVENESS AND SAFETY OF OMALIZUMAB IN THE TREATMENT OF SEVERE UNCONTROLLED ASTHMA

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10.1136/ejhp-pharm-2020-eahpconf.247

Background and importance New biological antiasthmatic therapies have been recently developed. In the absence of comparative studies of these therapies, there is a need to provide a better understanding of their behaviour in the real world. Omalizumab is the first monoclonal antibody for the add-on treatment of severe allergic asthma (SAA).

Aim and objectives To evaluate the effectiveness and safety of omalizumab in SAA.

Material and methods A retrospective observational study was conducted in all patients with SAA who were started on omalizumab treatment since 2009. Through pharmacy recordings and electronic clinical records, we collected demographic variables, treatment data (mean dose at baseline and changes during treatment, treatment duration until the last medical review (LMR), need for oral corticosteroids (CO)), forced expiratory volume in 1 s (FEV₁), scores in the asthma control test (ACT), adverse drug reactions (ADR) and reasons for treatment discontinuation.

Results Forty-six patients were included, 63% women, median age 45 years (range 10–74). The mean values for FEV₁ at baseline, week 16 and LMR were 65±17%, 77±18% and 80±20%, respectively. FEV₁ >80% was reached in 58.7% (27/46) of patients; in 26% (12/46) it increased by an average of 13% although FEV₁ >80% was not reached. In the remaining patients (15.3% (7/46)), FEV₁ decreased by an average of 11% compared with baseline. Data from the ACT questionnaire were recorded in only 37% (17/46) of patients with the following results: total control (ACT >25) in 23.5% (4/17), good control (ACT 20–24) in 29.4% (5/17) and poor control (ACT <20) in 47.1% (8/17). At the beginning of treatment, 67.3% (31/46) of patients required daily administration of CO compared with only 10.8% after omalizumab treatment. Regarding ADR, 28% (13/46) of patients suffered any ADR. Treatment was stopped in 15 patients (inefficacy (n=5), ADR (n=5), non-compliance (n=1), clinical improvement (n=4)) after an average treatment duration of 24 months.

Conclusion and relevance Omalizumab improved lung function in patients with SAA, eliminating the use of CO and with an acceptable safety profile. We noticed that there is a need to improve the registration of some clinical parameters in order to ensure adequate therapy monitoring that will help to provide knowledge of the role of each of these therapies.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.